Discussion Points

1 Advance prescribing of emergency hormonal contraception (EHC) does not increase repeat use nor encourage risk-taking behaviour. If money was not an issue, how would you go about providing this (e.g. on demand, for every client who chooses condoms or fertility awareness as their only method of contraception, outreach environments, at time of termination of pregnancy)? Would there be any disadvantages to advance prescribing?

2 Women seeking EC may have also risked STIs. Should screening be available to all women seeking EC, regardless of whether they opt for an emergency IUD? Should all having emergency IUD have prophylactic antibiotics?

3 How will you ensure that women get the correct advice on starting regimes for hormonal contraception and the need for additional barrier protection at a time when the Summary of Product Characteristics may not yet reflect the 2002 WHO *Selective Practice Recommendations for Contraceptive Use* data?

4 Patient Group Directions may be developed to include indications outside the licence for EHC if agreed with the Trust. There seems to be such local variation that it may be difficult to give national guidance on what can be included. Discuss how you would approach these issues and in which off-license situations would patients benefit from having their needs met at the first point of contact with a nurse or pharmacist.

Questions for Recommendations for Clinical Practice Emergency Contraception

Indicate your answer by ticking the appropriate box for each question

		True	*False*
1	Pharmacists can sell Levonelle to women younger than 16 years.	☐	☐
2	Repeat doses of Levonelle-2 may be issued outside the licence in any one cycle.	☐	☐
3	Liver enzyme inducers taken concurrently or within the previous 28 days would require an increase in dosage of Levonelle-2 by 50%.	☐	☐
4	Efficacy of POEC between 73 and 120 hours after intercourse has been found in a WHO study (2002) to be greater than previous WHO data between 49 and 72 hours.	☐	☐
5	EC is not required unless injection of Depo-Provera is delayed until more than 14 weeks and UPSI has occurred.	☐	☐
6	Severe hypertension is an absolute contraindication to emergency hormonal contraception (EHC).	☐	☐
7	The copper IUD can be inserted any time up to 5 days beyond predicted ovulation, regardless of how many acts of UPSI have occurred that cycle.	☐	☐
8	There is evidence that IUDs with 380 cm^2 copper are more effective than those with less copper in the emergency situation.	☐	☐
9	The use of EHC protects against pregnancy for the rest of the current cycle.	☐	☐
10	There is good quality evidence to support one dose of 1.5 mg levonorgestrel in place of two doses of 0.75 mg (current regimen) in everyday practice.	☐	☐

Answers

1 False
2 True
3 True
4 True
5 True
6 False
7 True
8 False
9 False
10 False